interval in association with a dilated heart, may be either a sound separated by an interval both from the second or the first sound, or it may be a low-pitched presystolic rumble, which may also alternate with a diastolic sound. The presystolic rumble of a dilated heart is probably too low pitched to give much difficulty in diagnosis, and when changed for a diastolic sound the accentuation and rhythm may be that of the *bruit de galop.* But there is, he believes, a diastolic murmur heard in the dilated heart of children which is presumably due to that dilatation and is indistinguishable from the diastolic sound of mitral stenosis. It may be best heard at the impulse or just outside, or over the right ventricle in the third and fourth or fourth and fifth intercostal spaces. In one position it is probably produced in the left ventricle, in the other in the right. In the same heart it may sometimes be best heard in one position, sometimes in the other, and then points probably to general dilatation. Whether such a murmur indicates mitral stenosis or dilatation of the heart is a question of some importance. The most common cause of dilatation is adherent pericardium, and death from this condition is much more common in children than from mitral stenosis; so that the immediate prognosis of a diastolic sound indicating a dilated heart is much graver than that of one pointing to mitral stenosis.

THE COEXISTENCE OF INFECTIOUS DISEASES.

CAIGER (*British Medical Journal,* May 5, 1894, p. 969), at a recent meeting of the Epidemiological Society, presented a study on the coexistence or close succession of two or more infectious diseases in the same individual. His experience at Stockwell, he said, had satisfied him that such concurrence of infections was as frequent as mere probabilities would explain, and that, so far from affording protection against other diseases, some certainly increased the susceptibility thereto. In the last four years he had seen 362 cases of two and 17 of three diseases running some part of their courses concurrently; in 200 of these the acute febrile stages of two or three coincided. The priority of the several diseases was calculated from their known incubation periods. The primary disease was scarlatina in 197, which was complicated by diphtheria in 97 cases; varicella, in 43; measles, in 31; whooping-cough, in 13; erysipelas, in 10; enteric fever, in 2, and typhus, in 1. Scarlatina was a complication in no fewer than 88 among 97 in which the primary disease was diphtheria; in 20 among 23 of varicella; in 14 of 17 of whooping-cough; in 6 of 9 of enteric, and 9 of 18 of measles, though here diphtheria accounted for another 7. Among the 17 triple attacks scarlatina was the primary disease in 9, and a complication in 4 only, diphtheria holding the highest place with 9. During the past six years 48,367 cases of scarlatina had been admitted into the hospitals of the Asylums Board; of these 3166, or 6.54 per cent., were complicated, 1094 with diphtheria, 899 with varicella, 703 with measles, and 404 with whooping-cough; the relative numbers of diphtheria and whooping-cough being probably owing to the fact that many had already had whooping-cough in infancy, while diphtheria, though less frequent, might and often did recur: these four diseases accounted for 3100, or all but 66. The questions suggested by these figures were: (1) Did any disease render the individual less or more susceptible to infection by another? (2) Did the primary disease in any way influence the course or character of the secondary one as regards (*a*) incubation, eruption, etc., periods; (*b*) severity of the disease; (*c*) distribution of local phenomena; (*d*) liability to sequelæ and other complications? The conclusions at which he arrived, after eliminating the influence of age incidence, seasonal prevalence, actual frequency, etc., were, first, that there was no such thing as antagonism between any, but rather the reverse, increased susceptibility being brought about, generally or locally; that is, first, by the lessened power of resistance induced by a disease attended with grave constitutional disturbance; and, secondly, by the local inflammations facilitating the development of the contagia of diseases known to affect the mucous membranes or tissues in question. Thus, an attack of varicella exerted no influence on any that might follow, but when scarlet fever was the primary disease, varicella, favored also by the quasi-dermatitis left behind, might rival unmitigated smallpox in intensity of fever and extent of eruption. Scarlatina was frequent and dangerous after diphtheria, but diphtheria following scarlatina was still graver, since the scarlatinal throat, teeming with staphylococci and streptococci, was a perfect soil for the bacillus of Loeffler. So, too, while the general phenomena of measles might be aggravated by previous diphtheria or scarlatina, and in the latter conjunction the rash would be intensified, an attack of diphtheria following on measles was even graver than the post-scarlatinal, since it inevitably attacked the larynx and trachea, and tracheotomy was very rarely of any avail. Measles and whooping-cough were known to follow one another or to coexist, mutually increasing the susceptibility of the individual. The author had never found the incubation period of a disease affected, but the presence of scarlatina accelerated the appearance of the rash in measles by a couple of days.

MEASLES COMPLICATED BY SUBCUTANEOUS EMPHYSEMA.

VARNALI, of Bucharest (*Revue mensuelle des Maladies de l'Enfance*, May, 1894, p. 266), reports such a case occurring in a child of ten years. The patient, when seen with the disease in full eruption, presented over the whole trunk and neck a subcutaneous emphysema; over the præcordial region there was a gaseous tumor the size of an orange. The disease was of four days' duration, and was uncomplicated by broncho-pneumonia; the emphysema had appeared suddenly after a paroxysm of coughing, followed by vomiting. The child had had an attack of whooping-cough about seven or eight months previously.

The author discusses the question of causation to explain how in the violent convulsive paroxysms of a whooping-cough the accident had failed to occur, but had followed a simple attack of catarrhal cough of measles several months later. He offers the following hypothesis: that the microbe of measles, whether that of Babes or another, had produced in the bronchial vessels a congestion and diapedesis, and that this lesion had caused atelectasis of some pulmonary lobules, with vicarious emphysema of other lobules. In the case of the patient, the old lesions left by his whooping-cough, in conjunction with the new, had produced a high intra-pulmonary tension, whence the rupture of a vesicle near the hilum and the production of the subcutaneous emphysema by way of the anterior mediastinum.